BUREAU TALK

Missouri Department of Health and Senior Services **Volume 06-1 – April 2006**
Bureau of Home Care and Rehabilitative Standards

THIS INFORMATION SHOULD BE DIRECTED TO THE MANAGEMENT STAFF OF YOUR AGENCY

STAFF CHANGES

As you know, change is inevitable and our Bureau is no exception. Melissa Hall who was the OASIS Technical Coordinator for the State of Missouri has recently resigned. Debi Hytla, whom many of you know already from our Bureau, has now been promoted to the new OASIS Technical Coordinator. She can be reached at 573/751-6332. Please join us in congratulating Debi in her new position!

As many of you may recall in April of 2005 David Atkinson, office support assistant, was let go due to budget cuts. Well, good things come to those who wait! David was rehired Nov 1, 2006 and is again back with our Bureau. We are very pleased to have his humor & upbeat attitude back in the office! He keeps us all laughing! Join us in welcoming David back! He can be reached at 573/751-6336.

Effective December 2005 the Unit became a Bureau again. The official title is Bureau of Home Care and Rehabilitative Standards. All correspondence should be sent to Missouri Department of Health and Senior Services, Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO 65102. If you are sending mail overnight you need to address your mail to 930 Wildwood Drive, Jefferson City, MO 65109.

NEW HOME HEALTH CoP'S

There were some changes to the Conditions of Participation for Home Health in May of 2004 and again in August of 2005. We now have an updated copy of the current Conditions of Participation. This current copy can be obtained for your use by downloading "**Attachment A**". Changes noted from the May 2004 update are in red and changes that were made in August 2005 are noted in blue.

Attention OPT & CORF's

Effective October 21, 2005 there were revisions to the State Operations Manual (SOM), Chapter 2, "The Certification Process" Appendix E – "Providers of Outpatient Physical Therapy or Outpatient Speech Language Pathology (OPT/OSP) Services and Appendix K – "Comprehensive Outpatient Rehabilitation Facilities" see "Attachment B".

Subject: Highlighted Revisions to Chapter 2, "The Certification Process,"

Appendix E — "Providers of Outpatient Physical Therapy or Outpatient Speech Language Pathology (OPRT/OSP) Services. "

Regarding 485.711 (c) Standard: Emergency Care

Just dialing 911 incase of an emergency during operation hours is not enough.

The organization provides for one or more doctors of medicine or osteopathy to be available on call to furnish necessary medical care in the case of emergency. The established procedures to be followed by personnel in an emergency cover immediate care of the patient, persons to be notified, and reports to be prepared.

Organizational policies should contain the names and telephone numbers of physicians(s) the organization has arranged to be on-call to provide medical care in case of an emergency during operating hours. (This can include physicians at a near-by hospital emergency room.) There may be instances in which the on-call physician provides emergency medical triage, which results in a 911 call. The OPT procedure to call 911 in cases of emergency doesn't supersede the requirement to have on-call physicians for emergencies.

Note: If an OPT/OSP is providing services at a community facility (such as a pool), the OPT staff must have a way to contact emergency medical care (i.e., if therapy services are being provided at a community pool, is another individual on duty and available to call for help?)

I-54

(Rev. 13, Issued: 10-21-05; Effective/Implementation Date: 11-21-05)

There must be two persons on duty whenever a patient is being treated (no matter where the services are being provided (485.723(a)(6)) and no matter whether the facility is large or small.)

Note: If a patient receives emergency medical treatment at the organization, the physician's emergency medical treatment plan and communication should be documented in the patient's medical record.

485.717 Condition of Participation: Rehabilitation Program

A significant change has been made by CMS in surveying for compliance with this Condition of Participation. All patients must be evaluated for need for social or vocational services, however, surveyors will no longer require proof that all patient's received a face to face evaluation by a qualified social worker, psychologist or vocational adjustment specialist. The revised interpretation of the Condition of Participation allows the therapist to use a screening tool or other written method to gather information for review by qualified staff. The surveyor would expect to see documentation in the patient's clinical record substantiating the qualified social worker; psychologist or vocational specialist has reviewed the information and made a determination whether the patient required further evaluation or services.

CMS guidance to surveyors state:

A qualified therapist can gather and document evidence regarding the need for social or vocational services via a screening tool or other written method deemed appropriate by the rehabilitation agency. The social worker, vocational adjustment specialist, or psychologist who will then determine the patient's need for further evaluation must review this written documentation. This process must be documented in the patient's clinical record. If further evaluation or services are needed the agency's special qualified staff must provide them or make appropriate referrals. Under no circumstances may a patient determine his or her vocational needs.

485.721 (f) Standard: Location and Facilities

Clinical records must be easily retrievable and available to all professional staff members of the organization and other authorized individuals. Clinical records may be maintained at a site other than the primary location (the site issued the provider agreement/number) if the beneficiary receives outpatient therapy services at that other site. All records must be available to the surveyor during the course of the survey regardless of where the records are kept.

AGENCY CHANGES

We can't remind agencies enough…. To all types of providers…. Please remember, any change in the status of your agency needs to be reported to our Bureau. The Bureau *MUST* be notified of any change in advance, as some changes require pre-approval by both the State and Medicare. *All requests for changes must be submitted in writing.* Changes can be as minor as a phone number to major changes such as ownership or location, but any change needs to be documented and mailed or faxed to our office *on agency letterhead.*

Also, the office staff requests that any correspondence sent in to the office be labeled with your *provider number*. Because there are some agencies that have the same name but different locations throughout the state it is very helpful to the office staff to know which agency the correspondence pertains to. It saves them a phone call to your agency!

HOSPICE CoP'S

New provision to Medicare Conditions of Participation Subpart B

418.25 – Admission to hospice care

This is a new provision in Subpart B of the Hospice Conditions of Participation.

During the hospice survey the surveyor will look for documentation to substantiate the medical director was given, at a minimum, the following information prior to making a decision to admit the patient to hospice.

(1) The terminal diagnosis
(2) Co-morbidities
(3) Current clinically relevant information supporting all diagnosis such as: current history and physical, Karnofsky score, Palliative Performance scale.

There does not need to be a face-to-face consult between the attending physician and the medical director. The nurse may give the information directly to the medical director or it may be faxed or mailed.

The medical information given to the medical director for consideration must be retained in the clinical record.

FCSR/EDL/CRIMINAL DISCLOSURE STATEMENT

"What a surveyor looks for during a survey visit":

HOME HEALTH

Prior to *patient contact*: (not employment) (Chapter 660 MO Revised Statutes, Section 660.317 August 28, 2005)

- Confirm criminal history disclosure statement
- Verify employee registered with the FCSR (copy of registration in file)
- This will give you the following information, which is also required before patient contact:
    - EDL
    - Criminal Background Check
- If FCSR done but no results back agency **must** have at least the EDL results before patient contact.

Home Health Agency Responsibility:

- Assure FCSR background screening results on file
- Assure employee with a class A or B Felony, crime against person does not have patient contact unless a Good Cause Waiver has been granted.
- Assure employee with any other FCSR finding does not have patient contact without a Good Cause Waiver application having been submitted to the department.
- Assure that confirmation of Good Cause Waiver is in files, if appropriate.

<u>In Personnel file for employee with a FCSR Finding:</u>

- Copy of the Good cause Waiver Application
- Copy of the Results of the Good Cause Waiver (Confirmation # 1-866-422-6872)

FCSR/Good Cause Waiver Access Line

1-866-422-6872 (Mon-Fri 7:00 am – 6:00pm)

INTERNET SITE www.dhss.state.mo.us/FCSR

HOSPICE

(Everything is the same as for home health agencies except RSMo 660.317 <u>Does NOT</u> require Hospice employers to obtain a FCSR screening, however, the Hospice may choose the FCSR to obtain information.)

Prior to patient contact:

- Confirm criminal history disclosure statement
- EDL
- Criminal background check

ADVISORY COUNCIL MEMBERS

The new home health and hospice advisory council members appointed by the Director of Department of Health and Senior Services, Julie Eckstein, is as follows:

<u>Home Health</u>:

(New Members)

- Carol Gourd (Consumer representative)
- Marcia Eckrich, Administrator (Lutheran Senior Services Home Health) *(Reappointed)*

- **(Existing Members)**
- Fern Dewert, RN (Surveyor, Department of Health & Senior Services)
- Carol Cronkhite, Supervising R.N. (Visiting Nurse Association)
- Erma Cunningham (Consumer representative)
- Angela Littrell, Administrator (Boone Hospital Home Care)
- Gloria Metzger (Consumer representative)
- Paul Reinert, Administrator (Integrity Home Care)
- Diane Lay, Administrator (Lewis County Home Health Agency

Hospice:

(New Members)

- Debbie Joy, Administrator (Benton County Health Department Hospice)
- Roxanne Reed-Johnston, Administrator (Missouri River Hospice)
- Yvonne Schwandt, Administrator (Pathways Community Hospice)

- *(Existing Members)*
- Mary Dyck, Administrator (Riverways Hospice)
- Jim Pierce, Resource Specialist (Hands of Hope Hospice)
- Claudette Jensen, RN (Representative from the Bureau of Home Care & Rehabilitative Standards)

SOM CHANGES

Please note: There was a recent change in the State Operations Manual. The ***surveyor*** now has 10 ***working*** days instead of calendar days to send out the statement of deficiencies to the agency following the completion of an onsite survey. However, the ***agency*** still only has 10 ***calendar*** days from the date of the receipt of the statement to return their plan of correction.

CMS PILOT STUDY FOR NEW HOME HEALTH SURVEY PROCESS

The Bureau of Home Care and Rehabilitative Standards has recently volunteered to partake in a CMS pilot study for a new HHA survey protocol. It consists of a doing a mock survey consisting of 8 clinical records, 3 mock home visit scenarios and 1 mock administrative interview using the current survey process, Then, in one month, the same records, scenarios & interview will be surveyed using a proposed new survey protocol. Several of our surveyors graciously volunteered to partake in the pilot study! Results from the pilot study are not expected to be available until at least mid to late summer. Stay tuned!

GROUP E-MAIL

At the end of 2005 the Bureau set up a group e-mail list for all the providers. This is currently how the Bureau is dispersing most information to the agencies. This process seems to be working fairly well. We want to remind all agencies to be sure and keep our Bureau updated when any changes in e-mail addresses occur. The administrator's e-mail address is a MUST but each agency has the option to submit two additional e-mail addresses if they wish. Please understand though that all information dispersed will then go to all three e-mail addresses. Because this is now the primary method of dispersing information, including annual statistical reports, it is imperative that we be notified of any changes in the e-mail addresses in order to keep the lines of communication open between the Bureau and your agency. We appreciate your attention to this!

TELEHEALTH

As we all know, there is a lot of discussion in the home health field about *telehealth.* The Bureau has recently consulted with Regional Office and CMS on whether a physician order is required for Telehealth. If telemedicine is used and it affects the patient's care plan than the agency will be required to have a physician order. This would pertain to both home health and hospice.

Agencies have asked if they can have "PRN" orders to go out and see a patient if, due to the telehealth, they have been alerted of a change in the patient's condition. The Bureau has cautioned agencies that if they include PRN visits on the 485 it needs to be for only 2 or 3 visits maximum and the order needs to specify the specific reason a visit needs to be made.

PULSE OXIMETRY

We know you have heard this before but the issue has come up a couple times again over the last couple of months. It never hurts to remind people right?
Does *pulse oximetry* require a physician order? It was brought to our attention that Joint Commission does require a physician order for pulse oximetry. However, it is our Bureau policy that, although surveyors often see physician orders for pulse oximetry, if there is not a physician order a citation will NOT be given.

MILEAGE RESTRICTIONS

The Bureau has been receiving a lot of phone call inquiries lately regarding whether or not there are any mileage restrictions for home health agencies. There are no mileage limitations for opening up a branch for home health. The home health agency must be able to adequately provide supervision from the parent agency. The only mileage restriction in the state guidelines is for hospice. A hospice satellite can be no more than 100 miles from the parent agency. Also, in hospice, the nurse must be able to reach the patient within 1 hour of receiving a call. There are also no mileage restrictions for OPT.

HOME HEALTH HOTLINE

Effective 11/14/05, the CRU (Central Registry Unit) began taking the home health & hospice hotline calls. At this time the same phone number is to be used (1-800-877-6485). It is now answered 24 hours/day, 7 days/week. The surveyors are finding that the consents that the patients are signing, bill of rights, etc. tell home health agencies the hotline is answered 8am – 4:30pm M-F. Please update your information that you are giving your patients.

MASSAGE THERAPY

Do you have to have a physician order for massage therapy? Whether it's home health or hospice, we have no problems with a patient receiving massage therapy (or any other alternative medicine) **if:** there is a physician order, the massage therapist meets the guidelines for licensure (if required), there is an agreement between the providers (as with any therapist) and the therapist meets all the requirements of criminal disclosure statement, EDL, family care safety registry, Alzheimer's training, etc.

HOME HEALTH 2006 ANNUAL REPORT

How time flies! Many of you are probably thinking you just submitted your home health annual statistical report for **2005** & we are already talking about the **2006** report! This year your agency had an option to either submit your **2005** report electronically or by mail. However, next year you will be ***required*** to submit your ***2006*** report ***electronically.*** The final version of the 2006 Home Health Agency Annual Statistical Report is not yet available; however, there are a couple new changes to the upcoming report that we want to give the home health agencies (HHAs) now so you can begin collecting the data. These changes are: What is the number of Medicare PPS and Medicare Managed Care patients for unduplicated admissions. The new report will require agencies to separate these two figures. Total admissions and discharges also need to be separated by Medicare PPS and Medicare Managed Care. Another new data being collected will be the number of Medicare PPS episodes ended during the year (1/1/06 – 12/31/06).

As soon as the final version of the 2006 Statistical Report is available your HHA will be notified.

CIVIL FALSE CLAIMS ACT

As you all know, for HHAs 484.48(a) Tag G237 states, "Clinical records are to be retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations." Hospice regulations on the other hand, do not specifically give a time frame for record retention.

Our office recently received an inquiry regarding the need to retain records for at least 10 years due to the "Civil False Claims Act". We did some research and did find that the False Claims Act 31 U.S.C. Section 3731 (b)(2) False Claims Procedure, found at www.ffhsj.com/quitam/fca.htm, states: "A civil action under section 3730 may not be brought--…(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last."

For State and Federal licensure, home health agencies and hospices must at a minimum follow the State and Federal regulations. The information above regarding the False Claims Act is simply for your information. Any questions should be referred to your individual legal counsel.

HOME HEALTH ADVANCE BENEFICIARY NOTICE (HHABN)

In January 2006, Medicare (CMS) revised the HHABN. Previously, home health agencies (HHAs) have issued HHABNs related to the absence or cessation of Medicare coverage only when a beneficiary had liability protection under section 1879 of the Social Security Act (the Act). Consistent with the new revised HHABN, HHAs must now issue HHABNs in a broader set of circumstances in conjunction with their responsibilities under the home health Conditions of Participation (COPs). The new instructions for the revised HHABN can be found at www.cms.hhs.gov/BNI/. Click on the FFS HHABN link provided.

These instructions explain when the newly revised HHABN should be issued, take into account related changes associated with the expedited determination process implemented in 2005, and include additional changes to simplify notice policy for HHAs. Until May 30, 2006, HHAs may use either the 2005 version or the new version. It is recommended that HHAs switch to the new HHABN as soon as possible given that the former HHABN does not include appropriate language for all situations now addressed by the revised HHABN. **Use of the new HHABN is mandatory beginning May 30, 2006.**

COMPLAINTS

Unfortunately, complaints have been on the rise this past year, especially since the beginning of the first quarter of this fiscal year and especially in the hospice area. Some statistical information follows:

- **Home Health Complaints from 1/1/05 –3/7/06**
  - 27 Home Health complaints
    - 9 have occurred since 10/01/05.
  - 19 unsubstantiated allegations
  - 6 substantiated allegations
  - 2 pending investigation
- **Hospice Complaints from 1/1/05 – 3/7/06**
- 52 Hospice complaints
  - 22 have occurred since 10/01/05
- 28 unsubstantiated allegations
- 23 substantiated allegations
- 1 pending investigation

HOSPICE ISSUES

- ❖ STANDING ORDERS: During the survey process, the surveyors are going to start checking standing orders more closely. Some guidelines to remember when developing your agency's standing orders:
  - Each procedure, medication or treatment should be addressed in a separate order on the overall standing orders.
  - Each procedure, medication or treatment should have specific criteria or qualifications for use such as the medical indication, purpose or conditions of use. These criteria should be as specific as possible and not allow nurses' choice. (Nurses cannot practice medicine)
  - Standing orders should not include normal teaching processes, instructions to caregivers, etc.
  - Standing orders must be signed and dated by the physician.
  - There should be policies in place as to when and how to use the standing orders and a method to show physician notification of use of standing orders.
  - Standing orders must be patient individualized.
  - No narcotics on standing orders.

❖ VOLUNTEER HOURS: A teleconference was recently held to aid hospices in filling out their statistical reports. One of the outcomes from this teleconference was that agencies wanted a clarification in a newsletter as to how to calculate their percentage of volunteer hours.
To calculate the percentage of volunteer hours – Divide the volunteer hours (administrative & direct) by the paid direct patient care hours (not the administrative hours) to get your percentage.

Another topic of discussion was "direct patient care hours" and how the Bureau defines it.

At a **minimum** this would be calculated as time spent in the patient's home.

News from the OASIS MOO arena....

- On 12/23/05 a new federal regulation pertaining to the 7-day lock period for OASIS was published. This regulation will be in effect 6/21/06. Under Section 484.20(a) of the CFR, the requirement to lock data within 7 days of the MOO90 date will be removed. Currently, the rule is that the agency must lock within 7 days of completing the comprehensive assessment and transmit by the end of the following month. Agencies will now be required to encode and transmit completed OASIS data without edit warnings up to 30 calendar days from the date the assessment was completed. This gives the agency more time to assure a correct OASIS assessment. You can obtain a copy of the regulation by going to www.gpoaccess.gov/fr/index.html. Go to 1994-2006 and search for 2005. Look for the 12/23/05 date and then the OASIS regulation under Centers for Medicare and Medicaid Services.

  Please note: policies and procedures must be established to reflect this change.

- The Bureau of Home Care and Rehabilitative Standards has recently taken on the position of the OASIS Technical Coordinator as well as the OASIS Education Coordinator. For any questions regarding the technical component of the OASIS please call Debbie Hytla at 573-751-6332. Debi is in the process of compiling a master of all the e-mail addresses for anyone who does the OASIS submissions at your agencies. In order for your agency to be assured of getting all the most updated information from our office, please submit your e-mail addresses to Debi as soon as possible. Her e-mail address is Deborah.Hytla@dhss.mo.gov.

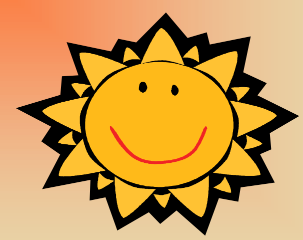
- The monthly OASIS training sessions are going great! We've had a full house each week! So far the evaluations have indicated that the trainings have been helpful. By limiting them to 9 – 10 people, the participants have found that they are very informal. Through the month of March, the training sessions have been twice monthly. Due to preparing for the MAHC conference in April there will only be one training that month and then starting in May through the summer months the trainings will be continued monthly. Due to vacations and staffing issues through the summer months it seemed more practical to do the trainings on a monthly basis. If anyone is interested in signing up for the training sessions please call 573-751-6336. We are currently registering people for July.

- MAHC annual conference is being held April 26-28, 2006. If you are attending come see the "Golden Girls vs OASIS" performed by the Medicare survey staff! Have you often felt it was a challenge to complete the OASIS assessment? We all know every assessment can be different, some easier than others. Well, you haven't seen anything yet! Come see how a nurse would perform the OASIS assessment with "Sophia" as her patient and Blanche, Dorothy and Rose as her loving caregivers!

- Just a reminder…CMS has asked that all states remind their HHAs that you need to have back-up procedures in place for your data bases. CMS still receives requests for data- base restores. Many of the requests can be eliminated by regularly backing up your files.

- At one of the recent OASIS training sessions, a question was asked about Residential Care Facilities (RCF). The answer given was that if a patient was living in an RCF they should be considered the same as living at home. This needs to be clarified. RCFs and Assisted Living Facilities (ALF) are often used interchangeably. Per a recent conversation with CMS and per Q & A's on the QTSO website, Category 4, #s Q58 and Q60, rules for licensing ALFs vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer for these situations must be selected that is most appropriate for the individual situation. If the patient would be receiving services that would be billed to Medicare by the ALF/RCF than billing by the HHA for the same services could be denied. The HHA would need to evaluate each case individually.

Happy Spring!!



From the Staff of the Bureau of Home Care and Rehabilitative